

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

#62-041554

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 27 Primary Registration District No. 4031 Registrar's No. 225

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. <del>FILED DEC 10 1962</del> a. COUNTY <b>Bates</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Bates</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Adrian</b>		c. CITY OR TOWN <b>Adrian</b>	
Length of stay in b <b>20 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) <b>Lulu Belle Highley</b>		4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Wfe.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME <b>Thomas Jefferson Laycock</b>		11b. MOTHER'S MAIDEN NAME <b>Thresa Nedora Tracy</b>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		12b. SOCIAL SECURITY NO. <b>No</b>	
13a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b>		13b. INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Atherosclerosis</b>		3 Mos.	
DUE TO (c) <b>Arterial Hypertension</b>		18 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
14. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	16. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Adrian Mo.</b>	
20g. COUNTY <b>Bates</b>		20h. STATE <b>Mo.</b>	
21. I attended the deceased from <b>June 2-1960</b> to <b>Dec 4 1962</b> and last saw her alive on <b>Dec 4, 1962</b> Death occurred at <b>7 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Carter W. Foster M.D.</b>	
22b. ADDRESS <b>Bates Mo.</b>		22c. DATE SIGNED <b>12/1/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Altona Cemetery</b>	23d. LOCATION (City, town, or county) <b>Altona Mo.</b>
24. FUNERAL DIRECTOR <b>Six Funeral Service, Adrian, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-8-62</b>	
26. REGISTRAR'S SIGNATURE <b>Norman Wilson</b>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Colandressif

Licensed Embalmer No. 3650

P. O. Address Adrian, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.